MONTANA STATE AUDITOR
MONICA LINDEEN
COMMISSIONER OF INSURANCE
COMMISSIONER OF SECURITIES
840 Helena Ave. ♦ Helena, MT 59601 ♦ 800-332-6148

INSURE MONTANA
EMPLOYER APPLICATION

Please complete and return to: **Insure Montana**
840 Helena Avenue
Helena, MT 59601
Fax: 406-444-3497

Applications are accepted on a first come, first serve basis. All available slots for the Insure Montana program are currently filled. Businesses will be placed on a waiting list in the order that their application has been received. For more info call 1-800-332-6148 or log on to www.insuremontana.org.

Demographic Information (must be complete)

Legal Name of Firm	Type of Entity (Corp., LLC, S-Corp, etc.)	Business Start Date	Federal Tax ID Number

Contact Name and Title	Owner's Name	Company Name to Appear on Statement	Type of Business

Address	City	State	Zip Code

Mailing Address if Different	City	State	Zip Code

Telephone	Fax	Email Address	State Tax ID Number

Please List Any Additional Business Owner(s)

Please answer the following questions.

1. How many employees/owners does this business employ? _____
2. How many eligible employees/owners* does this business employ? _____
3. How many eligible employees/owners* will or do currently participate in the group health insurance plan? _____

*"Eligible Employee," means any employee who works on a full-time basis with a normal workweek of 30 hours or more, except that at the sole discretion of the employer, the term may include an employee who works on a full-time basis with a normal workweek of between 20 and 30+ hours as long as this eligibility criteria is applied uniformly among all of the employer's employees. Owners are eligible employees if they work 20 hours or more a week at the business.

4. If applicable, please complete the related business information below (Related business may be any other business owned by the owners of this business or a family member of the owners. Family members include spouse, parents, siblings and children.):

Name of Business	Federal Tax ID Number

Please include the following information for all related businesses (in addition to applicant's employees):

Number of Employees	Estimated Number of Eligible Employees*

5. Do any employees or employees of a related business earn over $75,000 per year from this business or related business (excluding owners)? Yes ___ No ___

6. Does the business or any related business have delinquent state income tax liability owing to the Montana Department of Revenue for previous years? Yes ___ No ___

7. Has the applying business provided group health insurance in the past 24 months? Yes ___ No ___

If the answer is "YES" to question 7, go to question 14 (Tax Credit Section); otherwise, go to question 8 (Insurance Pool Section).

Insurance Pool Section

8. Is the business planning to apply for premium assistance and premium incentive payments, and then participating in the: a) Insure Montana Purchasing Pool through Blue Cross Blue Shield? Yes ___ No ___

OR; b) Obtaining group health insurance through a Qualified Association Health Plan? Yes ___ No ___

If yes, which Qualified Association Health Plan? _____

9. Please estimate the number of participants that may be covered under this plan in the following categories:

Dependent Children under 25 years of age _____

Single Adults (employees) 19 to 24 years of age _____

Employees' Spouses _____ Please estimate the ages of the spouses: ____ ____ ____ ____ ____

10. Please list the ages of eligible employees: ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

11. What percent of the employee-only premium does the business contribute? _____

12. Will the business contribute towards premiums for dependents? Yes ___ No ____

13. Please sign at the bottom of the form and submit.

Tax Credits Section

14. Does the business currently sponsor a small group health plan? Yes ____ No ____

15. Please list the current group health insurance company _____

Policy Number_____

Insurance company contact telephone number _____

Does the business pay premiums from a medical care savings account? Yes ____ No ____

16. What percent of the employee-only premium does the business contribute?_____

17. Is the business contributing to the employee's spouses or dependents? Yes ____ No ____

What are the ages of eligible employees? ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

If "YES", what amount is the business contribution for spouses? _____ and/or eligible dependents?_____

18. Please indicate the business' Federal tax filing status: _____

(For example: An S-corporation would file form 1120-S, a partnership would file a 1065, a C-corporation on a 1120-C, and a sole proprietor would file a schedule C attached to their individually filed 1040.)

19. Please sign at the bottom and submit.

By my signature below, I authorize my current health insurer to disclose to the State Auditor's Office all information relating to any health insurance premiums paid for this employer group, as well as any information pertaining to the number of employees and dependents covered under the employer group health plan that I sponsor. This authorization shall remain valid for as long as I continue to receive the tax credits and/or premium incentive/assistance payments referenced in this application form.

I agree that if I change my health insurance plan, or if the number of employees and dependents that are covered under this health plan changes, I will notify the State Auditor's Office immediately but no later than 30 days from the date of the change.

I certify, under penalty of law, that all my answers are correct and complete to the best of my knowledge. I understand the penalty for withholding or giving false information (MCA 33-22-2009). I agree to provide documents to verify information on this application if requested. I understand that State staff may obtain documents and/or information to verify statements on this application.

Employer Signature _____ **Date** _____